STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. BUILDING 01 B. WING	09/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD HEALTHCARE CENTER	2400 COLLEGE AVE GOSHEN, IN 46526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Dates: 09/02/14 Facility Number: 000091 Provider Number: 155689 AIM Number: 100290080 At this Life Safety Code survey, Courtyard Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original section of the building consisting of the A Wing, B Wing, the C wing and the main dining room was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility was determined to be of Type V (111) construction and was fully sprinklered with the exception of a storage shed on the roof. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the	K 0000	**K000** Please accept this Plan of Correction as our facility's Credible Allegation of Compliance for our Life Safety Code Recertification and State Licensure Survey conducted on 9/2/15. Submission of this Plan of Correction is not an admission by Courtyard Healthcare Center that the deficiencies alleged in the survey are accurate or that they depict the level of safety and security provided to the residents of our facility. This Plan of Correction is being submitted solely because doing so is required by State and Federal law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	corridors. The resident rooms are provided with single station, hard wired smoke detectors. The facility has a capacity of 186 and had a census of 173 at the time of this survey. All areas where residents have customary access were sprinklered. The facility had a storage shed on the roof that was not sprinklered and two detached, garage sized storage sheds used for storage by the facility that were not sprinklered. Quality Review completed 09/10/15 - DA			
K 0018 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. 1. Based on observation and interview, the facility failed to ensure the doors protecting corridor openings in 4 of 33	K 0018	**K018** Facility will equip its corridor doors with latching mechanisms that meet the NFPA requirements and assure that	10/02/2015

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	resident rooms on Birch wing were smoke resistive. This deficient practice could affect 21 residents on Birch wing. Findings include: Based on observation during a tour of the facility with the Assistant Maintenance Technician and the Housekeeping Supervisor on 09/02/15 at 10:28 a.m., there were pencil size holes by the door knobs in the corridor doors of rooms, 107, 117, 128, and 129. Based on interview at the time of observation, the holes were acknowledged by the Assistant Maintenance Technician and the Housekeeping Supervisor. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 33 resident room corridor doors on Cedar wing closed and latched into the door frame. This deficient practice could affect 26 residents on Cedar wing. Findings include: Based on observation during a tour of the facility with the Assistant Maintenance Technician and the Housekeeping Supervisor on 09/02/15 at 12:00 p.m., the		said doors are smoke resistive. **Corrective Actions:** The pencil-sized holes near the door knobs of the corridor doors noted in the 2567, namely those leading to resident room numbers 107, 117, 128, and 129 have been repaired. Automatic smoke detector has been installed in the Staff Lounge. The corridor door noted in the 2567, that leads to room number 218, has been repaired so it latches appropriately. The set of double corridor doors noted in the 2567, those leading from the Candlelight Dining Room to the Staff Lounge, has been reconfigured to include positive latching as per NFPA. A smoke detector has been installed in the Staff Lounge. **How Others Identified:** Hazard Rounds of the building were conducted to determine what other doors may be similarly deficient. **Preventative Measures:** These three doors will be placed on a Preventive Maintenance Schedule, where they will be checked to assure that they latch appropriately. These checks will occur weekly for the next six months, at which time their frequency may be reduced at the direction of the facility's QAPI Committee. **Monitoring:** The results of the PM checks notedunder "Preventative Measures" (above) will be submitted to the facility's QAPI Committee for review on a	

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	corridor door to resident room 218 failed to latch into the door frame. Based on interview at the time of observation, this was acknowledged by the Assistant Maintenance Technician and the Housekeeping Supervisor. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 sets of double corridor doors to the staff dining room closed and latched automatically into the door frame. This deficient practice was not in a resident care area but could affect staff using the dining room. Findings include: Based on observation during a tour of the facility with the Assistant Maintenance Technician and the Housekeeping Supervisor on 09/02/15 at 11:25 a.m., the staff dining room was provided with a set of double corridor doors. The first of the double doors was equipped with a manual interior slide latch that latched into the frame. The second door positively latched into the first door. Additionally, there was a manual exterior slide latch. Additionally, the staff dining		monthly basis for the next six months. **Date of Completion: October 2, 2015**	

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	room was not protected by an automatic smoke detector. Based on interview at the time of observation, this was acknowledged by the Assistant Maintenance Technician and the Housekeeping Supervisor. 3.1-19(b)			
K 0025 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect all residents in all smoke compartments. Findings include:	K 0025	**K025 NFPA LIFE SAFETY CODE STANDARD** Facility will continue to ensure that smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. **Corrective Actions:** The smoke barrier penetrations noted during the survey have been repaired. **How Others Identified:** As noted in the 2567, this alleged deficient practice could affect all of the facility's residents. **Preventative Measures:** Smoke barriers	10/02/2015

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	Based on observation during a tour of the facility with the Director of Maintenance, Assistant Maintenance Technician, and the Housekeeping Supervisor on 09/02/15 between 10:00 a.m. and 1:00 p.m., the following unsealed penetrations were noted: a.) in the ceiling of the electrical room in the maintenance shop there were 17 unsealed penetrations around electrical conduits measuring a quarter inch to a half inch in size. b.) in the ceiling of the of the Birch wing server closet there was an unsealed penetration around the call light wires measuring two inches in size. c.) in the ceiling of the Birch wing storage room there was an unsealed penetration around a sprinkler head measuring one and a half inch in size. d.) in the ceiling of the speaker room adjacent to the main dining room there were 7 unsealed penetrations around electrical conduits measuring one inch in size. e.) in the ceiling of the computer server room by the main dining room there were 2 unsealed penetrations around electrical conduit measuring a quarter inch to a half inch in size. f.) in the ceiling of the of the Cedar spare storage room there was an unsealed penetration around the call light wires measuring two inches in size.		have been placed on a schedule whereby they will be visually checked for compliance with K025 monthly for the next six months. Documentation of these observations will be forwarded to the facility's QAPI Committee for review. **Monitoring:** The results of the visual checks completed under "Preventive Measures" (above) will be reviewed by the facility's QAPI Committee at each meeting it holds in the next six months. **Date of Completion: October 2, 2015**	

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	Based on interview at the time of observation, the Director of Maintenance, Assistant Maintenance Technician, and the Housekeeping Supervisor acknowledged and provided the measurements of the penetrations. 3.1-19(b)			
K 0038 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 delayed egress locks in the Birch wing was readily accessible for residents, staff, and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not	K 0038	**K038 NFPA 101 LIFE SAFETY CODE STANDARD** Facility will continue to have its exits arranged so as to be readily accessible at all times. **Corrective Actions:** The Birch Wing multi-purpose room door, noted in the 2567, has been repaired so as to provide for the 15/3 second requirements noted on page 6 of the 2567. The Dining Room exit has been equipped with signage indicating "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". The activity room doors, noted in the 2567, have been equipped with appropriate signage. **How Others Identified:** This alleged deficiency has the potential to affect all of the facility's residents. **Preventative Measures:** Maintenance Supervisor has been trained on the delayed egress requirements noted in	10/02/2015

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	be required to exceed 15 seconds nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 33 residents, staff and visitors in the Birch hall. Findings include: Based on observation during a tour of the facility with the Assistant Maintenance Technician and the Housekeeping Supervisor on 09/02/15 at 10:45 a.m., the exit door located in the Birch multipurpose room leading to the exterior of the building is marked as a facility exit, is equipped with a delayed egress lock, and is provided with necessary signage stating the door could be opened in 15 seconds by pushing on the door release device. However, the exit door failed to open within 15 seconds when the door was pushed with the application of force five separate times. Based on interview at the time of observation, the Assistant Maintenance Technician and the Housekeeping Supervisor stated the aforementioned exit is a facility exit, is equipped with a delayed egress lock and		"K038". **Monitoring:** All of the facility's exit and fire doors have been placed on a Preventative Maintenance schedule and will be checked for: (a) signage—if appropriate; (b)15/3 second requirements—if locked; and (c) latching—if fire doors. Said PM checks will occur weekly for the next six months, with the results forwarded to the facility's QAPI committee for review and follow-up. **Date of Completion: October 2, 2015**	

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	the necessary signage, but acknowledged the exit door failed to open within 15 seconds when the door was pushed with the application of force five separate times. 3.1-15(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 exit doors in the main dining room was accessible. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(d) requires on the door adjacent to the release device there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS " This deficient practice could affect 100 residents in the main dining room. Findings include: Based on observations during a tour of the facility with the Assistant Maintenance Technician and the Housekeeping Supervisor on 09/02/15 at 11:23 a.m., the exit door in the main dining room was equipped with			

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	electromagnetic locks that released after pushing the door for 15 seconds but lacked proper signage regarding pushing the door to open. Based on interview at the time of observation, the Assistant Maintenance Technician and the Housekeeping Supervisor acknowledged the door was equipped with a 15 second delay and there was not proper signage regarding pushing the door to open. 3.1-15(b) 3. Based on observation and interview, the facility failed to ensure the means of egress through 2 of 2 exits in the path of egress from the activity room were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice affects at least 10 residents in the activity room.			

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	Findings include: Based on observations during a tour of the facility with the Assistant Maintenance Technician and the Housekeeping Supervisor on 09/02/15 at 10:18 a.m., the exit doors in the activity room and in the sun room were magnetically locked and could be opened by entering a four digit code, but no code was posted to ensure the doors are capable of being readily unlock. The doors did not require locking because residents that had access to the doors do not have a clinical diagnosis to be in a secure building or wing. Based on interview at the time of observation, the Assistant Maintenance Technician and the Housekeeping Supervisor acknowledged there was no code posted at the two magnetically locked exits. 3.1-19(b)			
K 0044 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 3 fire door sets was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to	K 0044	**K044 NFPA 101 LIFE SAFETY CODE STANDARD** Facility will continue to ensure that its horizontal exists are in accordance with 7.2.4. **Corrective Actions:** The fire door noted in the 2567, leading to	10/02/2015

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	be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. This deficient practice could affect 20 residents in the Birch wing. Findings include: Based on observation during a tour of the facility with the Assistant Maintenance Technician and the Housekeeping Supervisor on 09/02/15 at 10:20 a.m., the fire door set entering the Birch wing failed to latch into the frame. Based on interview at the time of observation, this was acknowledged by the Assistant Maintenance Technician and the Housekeeping Supervisor and confirmed these were fire doors. 3.1-19(b)		Birch Wing, has been adjusted so it latches into the door frame. **How Others Identified:** All fire doors have been checked for proper latching. **Preventative Measures:** Maintenance staff have been trained on the specific requirements of fire doors and their proper functioning. **Monitoring:** All of the facility's exit and fire doors have been placed on a Preventative Maintenance schedule and will be checked for: (a) signage—if appropriate; (b) 15/3 second requirements—if locked; and (c) latching—if fire doors. Said PM checks will occur weekly for the next six months, with the results forwarded to the facility's QAPI committee for review and follow-up. **Date of Completion: October 2, 2015**	
K 0046 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on observation, and interview; the facility failed to ensure emergency light	K 0046	**K046 NFPA 101 LIFE SAFETY CODE STANDARD** Facility will continue to supply emergency	10/02/2015

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	fixtures for 2 of 2 generators were tested annually for 1½ hour duration and monthly for 30 second duration in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency lighting system for a minimum of 1 ½ hour duration and every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review with the Director of Maintenance on 09/02/15 at 10:00 a.m., no documentation was available for review to show the testing of the emergency battery powered lights at the facility's two generators. Based on interview at the time of record review, when ask if the emergency battery powered lights are tested 30 seconds monthly, 90 minutes annually, and if the tests are documented the Director of Maintenance stated the emergency battery powered lights are not tested for		lighting in accordance with 7.9. **Corrective Actions:** Emergency lighting, already in place at the time of the survey, was put on a Preventative Maintenance/testing schedule. **How Others Identified:** This alleged deficiency has the potential to affect all of the facility's residents. **Preventative Measures:** Maintenance Supervisor has been trained on the need to test emergency lighting for the generators. **Monitoring:** Testing of the emergency lighting of the generators has been added to the facility's Preventive Maintenance Program and records indicating that the lighting have been checked monthly will be reviewed by the Executive Director (and the facility's QAPI Committee) monthly. **Date of Completion: October 2, 2015**	

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	30 seconds monthly, 90 minutes annually, or documented. 3.1-19(b)			
K 0051 SS=B Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 Based on observation and interview, the facility failed to ensure 1 of 1 smoke detectors in the Cedar multipurpose room was installed where air flow would not adversely affect their operation. Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors.	K 0051	**K051 NFPA 101 LIFE SAFETY CODESTANDARD** Facility will continue to maintain its fire alarm system in compliance with K051. **Corrective Actions:** The smoke detector in the Cedar Wing multi-purpose room was moved so as to be located more than three feet from theair supply duct. **How Others Identified:** This alleged deficiency has the potential to affect all of the facility's residents. **Preventative Measures:** Maintenance	10/02/2015

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COURTYARD HEALTHCARE CENTER	2400 COLLEGE AVE GOSHEN, IN 46526

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	This deficient practice could affect 10 residents in the Cedar multipurpose room. Findings include: Based on observation during a tour of the facility with the Assistant Maintenance Technician and the Housekeeping Supervisor on 09/02/15 at 12:10 p.m., the smoke detector in the Cedar multipurpose room was located within three feet of an air supply duct. Based on interview at the time of observation, this was acknowledged by the Assistant Maintenance Technician and the Housekeeping Supervisor. 3.1-19(b)		Supervisor has been trained on the requirements noted in K051. **Monitoring:** Smoke detectors have been added to the facility's Hazards Rounds audit that was instituted as a part of the facility's Health Survey earlier this month. Hazard Rounds are being conducted weekly, and will be for the next six months. Results of Hazards Rounds are being submitted to the Executive Director (and the facility's QAPI Committee) for review and corrective action, if necessary. **Date of Completion: October 2, 2015**	
K 0062 SS=B Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler heads in the Cedar store room was continuously maintained in reliable operating condition. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for	K 0062	**K062 NFPA LIFE SAFETY CODE STANDARD** Facility will continue to ensure that required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. **Corrective Actions:** The paint noted in the	10/02/2015

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	the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 20 residents, in the Cedar wing. Findings include: Based on observation during a tour of the facility with the Assistant Maintenance Technician and the Housekeeping Supervisor on 9/02/15 at 12:05 p.m., paint was noted on the sprinkler head in the Cedar storage room. Based on interview at the time of observation, the Assistant Maintenance Technician and the Housekeeping Supervisor acknowledged there was paint on the sprinkler. 3.1-19(b)		2567, on the sprinkler head in the Cedar Wing storage room, has been removed. **How Others Identified:** All sprinkler heads in the building have been assessed head-by-head and each that was found to have paint on them have either had the paint removed or have been replaced. **Preventative Measures:** Sprinkler heads are on a Preventive Maintenance schedule whereby they will be checked for paint and corrosion every three months for the next year, with the results of this PM check being forwarded to the facility's QAPI Committee for follow-up and review. **Monitoring:** QAPI Committee will review the sprinkler head audits for the next year. **Date of Completion: October 2, 2015**	
K 0073 SS=B Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 Based on observation, the facility failed to ensure 1 of 133 resident rooms remains free of combustible decorations.	K 0073	**K073 NFPA LIFE SAFETY CODE STANDARD** Facility will continue to ensure that its furnishings and decorations are	10/02/2015

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	This deficient practice affects 2 residents in room 135. Findings include: Based on observations with the Assistant Maintenance Technician and the Housekeeping Supervisor on 09/02/15 at 10:45 a.m., there was an unlit candle with a wick in room 135. Based on interview at the time of observation, the Assistant Maintenance Technician and the Housekeeping Supervisor acknowledged there was a candle with a wick and stated they could not remove the candle at that time because they are not allowed to remove resident property without permission. 3.1-19(b)		not highly flammable. **Corrective Actions:** The wick in the candle in room #135 has been removed. **How Others Identified:** Facility has instituted Hazards Rounds whereby furnishings and decorations are being assessed for violations of K073. **Preventative Measures:** Hazards Rounds will be completed weekly for the next 8 weeks and monthly for the four months following those 8 weeks. Items found in violation of K073 will be removed when found during Rounds. Social Services, Admissions, and Maintenance staff will be in-serviced on what items are considered hazardous and the facility's protocol for handling said items. **Monitoring:** Hazards Rounds finding are being submitted to the Executive Director, who will summarize the finds and present them to the facility's QAPI Committee for review monthly for the next six months. **Date of Completion: October 2, 2015**	
K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords such as an extension cord was not used as a substitute for fixed wiring and failed to ensure 2 of 2 flexible cords were	K 0147	**K147 NFPA LIFE SAFETY CODE STANDARD** Facility will continue to ensure that its electrical wiring and equipment are in accordance with NFPA 70, National Electric Code.	10/02/2015

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	not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 4 residents and staff in rooms 118, 206 and housekeeping storage on Cedar wing. Findings include: Based on observation during a tour of the facility with the Assistant Maintenance Technician and the Housekeeping Supervisor on 09/02/15 Between 10:57 a.m. and 12:35 p.m., the following was noted: a.) a refrigerator was provided power by an extension cord power strip in room 118. b.) a microwave was provided power by an extension cord power strip in room 206. c.) A floor scrubber was provided power by an extension cord power strip that was plugged into a heavy weight extension cord. Based on interview at the time of observation, the power strips and extension cords were acknowledged by the Assistant Maintenance Technician		**Corrective Actions:** The power strips and extension cords noted in the 2567 have been removed. **How Others Identified:** Facility has instituted Hazards Rounds, which includes the identification and assessment of the use of extension cords and power strips. **Preventative Measures:** Hazards Rounds will be completed weekly for the next 8 weeks and monthly for the four months following those 8 weeks. Items found in violation of K147 will be removed when found during Rounds. Social Services, Admissions, and Maintenance staff will be in-serviced on K147 and hazards and the facility's protocol for handling said items. **Monitoring:** Hazards Rounds findings are being submitted to the Executive Director, who will summarize the finds and present them to the facility's QAPI Committee for review monthly for the next six months. **Date of Completion: October 2, 2015**	

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	and the Housekeeping Supervisor. 3.1-19(b)			
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Dates: 09/02/15 Facility Number: 000091 Provider Number: 155689 AIM Number: 100290080 Surveyor: Dennis Austill, Life Safety Code Specialist At this Life Safety Code survey, Courtyard Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The new 2011 addition of the building consisting of the D Wing was surveyed with Chapter 18, New Health	K 0000	**K000** Please accept this Plan of Correction as our facility's Credible Allegation of Compliance for our Life Safety Code Recertification and State Licensure Survey conducted on 9/2/15. Submission of this Plan of Correction is not an admission by Courtyard Healthcare Center that the deficiencies alleged in the survey are accurate or that they depict the level of safety and security provided to the residents of our facility. This Plan of Correction is being submitted solely because doing so is required by State and Federal law.	

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	Care Occupancies. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridors. The resident rooms are provided with single station, hard wired smoke detectors. The facility has a capacity of 186 and had a census of 173 at the time of this survey. All areas where residents have customary access were sprinklered. The facility had a storage shed on the roof that was not sprinklered and two detached, garage sized storage sheds used for storage by the facility that were not sprinklered. Quality Review completed 09/10/15 - DA			
K 0025 SS=F Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3,			

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	18.3.7.5, 18.1.6.3 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect all residents in all smoke compartments. Findings include: Based on observation during a tour of the facility with the Director of Maintenance, on 09/02/15 Between 10:00 a.m. and 1:00 p.m. the following unsealed penetrations were noted: a.) in the ceiling of the Dogwood janitor ' s closet there was an unsealed penetration around the call light wires measuring one inch in size. b.) in the ceiling of the Dogwood electrical closet there was an unsealed penetration around the call light wires measuring one inch in size. c.) in the ceiling of the Dogwood storage closet by the nursing station there was an unsealed penetration around the call light wires measuring one inch in size. Based on interview at the time of observation, the Director of Maintenance, Assistant Maintenance Technician, and the Housekeeping Supervisor	K 0025	**K025 NFPA LIFE SAFETY CODE STANDARD** Facility will continue to ensure that smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. **Corrective Actions:** The smoke barrier penetrations noted during the survey have been repaired. **How Others Identified:** As noted in the 2567, this alleged deficient practice could affect all of the facility's residents. **Preventative Measures:** Smoke barriers have been placed on a schedule whereby they will be visually checked for compliance with K025 monthly for the next six months. Documentation of these observations will be forwarded to the facility's QAPI Committee for review. **Monitoring:** The results of the visual checks completed under "Preventive Measures" (above) will be reviewed by the facility's QAPI Committee at each meeting it holds in the next six months. **Date of Completion: October 2, 2015**	10/02/2015

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	acknowledged and provided the measurements of the penetrations. 3.1-19(b)			
K 0046 SS=C Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 18.2.9.1 Based on observation, and interview; the facility failed to ensure emergency light fixtures for 2 of 2 generators were tested annually for 1½ hour duration and monthly for 30 second duration in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency lighting system for a minimum of 1 ½ hour duration and every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.	K 0046	**K046 NFPA 101 LIFE SAFETY CODE STANDARD** Facility will continue to supply emergency lighting in accordance with 7.9. **Corrective Actions:** Emergency lighting, already in place at the time of the survey, was put on a Preventative Maintenance/testing schedule. **How Others Identified:** This alleged deficiency has the potential to affect all of the facility's residents. **Preventative Measures:** Maintenance Supervisor has been trained on the need to test emergency lighting for the generators. **Monitoring:** Testing of the emergency lighting of the generators has been added to the facility's Preventive Maintenance Program and records indicating that the lighting have been checked monthly will be reviewed by the Executive Director (and the	10/02/2015

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	Findings include: Based on record review with the Director Maintenance on 09/02/15 at 10:00 a.m., no documentation was available for review to show the testing of the emergency battery powered lights at the facility's two generators. Based on interview at the time of record review, when ask if the emergency battery power lights are tested 30 seconds monthly, 90 minutes annually, and if the tests are documented the Director of Maintenance stated the emergency battery powered lights are not tested for 30 seconds monthly, 90 minutes annually, or documented. 3.1-19(b)		facility's QAPI Committee) monthly. **Date of Completion: October 2, 2015**	